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GENETIC AND ENVIRONMENTAL FACTORS IN
PSYCHOSIS OF ONE HUNDRED WOMEN OF SUPERIOR INTELLIGENCE

A Thesis

Submitted by

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In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service

1947

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PSYCHOLOGY OF ENVIRONMENTAL FACTORS IN
GENEAL AND ENVIRONMENTAL FACTORS IN

School of Social Work

Nov. 7, 1947

1885

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"Intelligence is, without doubt, the greatest single endowment of the human race. It has made possible the most prized achievements of the past and it will make possible the realization of the highest hopes of the future. It is the primary source of all progress. Granting the vast importance of intellect in the affairs of man, it surely follows that it is desirable to nurture it, especially where it is found to exist in high degree."

Herbert A. Carroll, Genius in the Making, vii.

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CHAPTER I

INTRODUCTION

General Analysis

This thesis project was undertaken to describe and to analyze a group of selected psychotic women patients known to have superior intelligence, and to attempt to evaluate the hereditary and environmental factors contributing to their illness. By "superior intelligence" we mean those who test above average on standardized scales for the measurement of intelligence. No distinction is made between those classified as Superior and Very Superior. In this Metropolitan State Hospital there are one hundred women whose scores from intelligence tests administered following admission classifies them as having superior intelligence. "Psychosis" is the term given to the deeper, more far-reaching and prolonged mental disorder in which there is such personality change that the individual is no longer able to function in a normal environment and requires hospitalization. Cantor describes the difference between the normal mind and a diseased one as follows:

A normal mind is one which has achieved a satisfactory dynamic balance between the need for self-expression and the need for self-repression. A person with a normal mind possesses a feeling of inner confidence and a lack of disruptive fear. The normal mind maintains the equilibrium of the personality when it experiences hostility, frustration, deprivation, and other strains inherent in the process of

living. When emotional stresses become too great for some individuals, or when they suffer various types of deprivation beyond their capacity for constructive compensation the individuals become overwhelmed and withdraw from reality into a world of unreality in which they create their individual compensation. If the individual is not mentally defective but withdraws from reality to the point of mis-managing his own affairs, or is dangerous to himself and to others he is considered to have a psychosis. If there is no organic disturbance which is causing the individual's withdrawal from reality, he is considered to have a functional psychosis. This psychosis represents the inadequate functioning of the personality in its particular life situation.¹

The principal source of information is the hospital medical and social record; this includes the family history, the personal history, information regarding education, health, employment, marital experience and incidents which relate to the onset of the mental illness. In a few cases reports were available from colleges and employers. The intelligence test reports and interpretation are included as part of each record. In addition the writer interviewed sixty-two of the women studied. Personal interviews with relatives yielded much information regarding early development. Patients admitted to this State Hospital are residents of the Boston Metropolitan area. Two of the women became psychotic while living out of the State and were transferred to this hospital. Each record was studied with the aid of a schedule

¹ Nathaniel Cantor, "What is a Normal Mind?" American Journal of Psychiatry, November 1941, p. 51.

designed to summarize the information including the history of mental illness among each patient's antecedents, outstanding traumatic events of early childhood, educational achievement, success in chosen line of work, marital history and present status.

There are many ways to study a selected group. The writer has chosen to study the hereditary and environmental factors of one hundred psychotic women of superior intelligence; selecting those factors which are common and may by virtue of frequency be described as contributory to the mental illness. Information was gathered from individual histories regarding the genetic traits, the pressures of environment, and the conflicts that were developed from these influences. The question of hereditary mental disease is debatable and receives less and less acceptance as additional studies and research are made. Dr. Ives Hendricks gives the psychiatric use of the term:

Today in psychiatric usage, "heredity" or "constitution" has actually come to be used chiefly to disguise ignorance, in that everything we cannot explain is ascribed arbitrarily to it. When we find that an environmental situation plays a role in a specific maladjustment, the role of heredity is less emphasized; the disclosure of adult traumata which have become unconscious still further reduces its significance, and the demonstration of infantile repressions do so still more. At this point, however, analysts are compelled to join their colleagues in assigning what is still inexplicable to hereditary causes. There is no reason to doubt that an individual with sufficiently inferior germ plasm cannot escape mental illness

under any life conditions; but it is also apparent that individuals whose heredity and infantile experiences are not unusually unfavorable may be made neurotic by exceptional strain. ²

Environmental influence is another controversial matter for "within a given family where similar environmental influences exist for each member, there are differences between siblings which lead us to believe that behavior and personality are products of the interaction of innate constitutional factors, especially capacities to respond in various ways, and the driving, modifying and repressing stimuli come from the environment." Dr. Lowrey believes "in general much more weight is usually ascribed to them (environmental factors) than is actually justified from what we know of the natural history of the psychoses." But clinical psychologists and psychiatrists do not deny that environmental situations may be described as contributing or precipitating factors in mental illness.

The most frequent diagnosis found in this study is schizophrenia in one of its reaction types. Seventy per cent of the patients in state hospitals have a diagnosis of schizophrenia which has been correctly described as the most serious disease menace of the present civilization. Over one-fourth of new patients admitted to mental hospitals each year

² Ives Hendricks, Facts and Theories of Psycho-analysis. p. 27.

are ill with one of the schizophrenic reaction types. The illness is more common to males and appears between the ages of fifteen and thirty years. The incidence is greater in cities than rural areas and among the foreign born than in native American stock. There is no inheritance in the strict Mendelian sense. There is a largess of symptomatology and a host of vaso-motor-sympathetic disturbances with frequent gastro-intestinal complaints. A stormy onset is a good omen. The types of schizophrenia are almost hair-splitting, readily over-flowing from one type to another, with all the important symptoms of the disease found in each type. Clinically four fairly well defined types are recognized:

1. Simple schizophrenia which is demonstrated by rapid deterioration of the emotional life and a paralysis of interest. With these patients words seem to take the place of action.
2. The hebephrenic type is distinguished by silliness, inappropriate smiling and laughter.
3. Catatonic schizophrenia is marked by phases of stupor and excitement. The behavior is impulsive, stereotyped, and hallucinated.
4. Schizophrenia, paranoid type, is presented by delusions with feelings of persecution and grandiosity; hallucinations are common.

Theories regarding its origin are at variance; some consider it hereditary, others believe basically it is the result of degenerative processes in the nervous system. It is possible that because of insufficient knowledge many disease entities are included under the term "schizophrenia." All agree on

the splitting of the psyche which is followed by losing contact with the environment. Stoddard says of them, "Our schizophrenics, for the most part, have gradually withdrawn from the business of life; they have "retired" long before their time. Most of them have been very unsuccessful in maintaining effective social relationships with the persons and things about them."

While this study does not give conclusive findings as to the predisposing factors of mental illness those found to be common to the group are pointed up and evaluated. It is hoped that some general conclusions may be drawn from this research that will enable one to know the reaction of these women of superior intelligence to certain hereditary traits and environmental conditions.

TABLE 1.
MEDICAL DIAGNOSIS OF ONE HUNDRED PSYCHOTIC WOMEN
OF SUPERIOR INTELLIGENCE

Medical Diagnosis	Number of Women
Dementia praecox (schizophrenia)	56
Simple	3
Catatonic	15
Hebephrenic	3
Paranoid	27
Other types, type undetermined	9
Manic Depressive, Manic	13
Manic Depressive, Depressed	4
Manic Depressive, Mixed	2
Paranoid and paranoid conditions; paranoid conditions	7
Alcoholic psychosis	3
Psychosis with psychopathic personality	3
Psychosis with arterio-sclerosis	2
Involitional psychosis, paranoid	2
Involitional psychosis, melancholic	1

CHAPTER II

DESCRIPTION OF ONE HUNDRED PSYCHOTIC WOMEN OF
SUPERIOR INTELLIGENCE AND STATISTICAL DATA

From this study we have general information which permits an analysis of some common characteristics of these psychotic women. The writer does not intend to make any specific conclusions from these but to point up the study in a form that provides summation. The women selected for this thesis project were admitted to the Metropolitan State Hospital and after a period of observation diagnosed as psychotic. As is common to all statistics of diagnosis that of dementia praecox (schizophrenia) exceeds all others, 56 of the women received this diagnosis.

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Psychosis with psychopathic personality	3
Psychosis with arterio-sclerosis	2
Involuntional psychosis, paranoid	2
Involuntional psychosis, melancholia	1

Psychosis associated with organic changes	1
Psychosis, simple deterioration	1
Senile psychosis, depressed and agitated	1
Psycho-neurosis	1

The second criterion was that of superior intelligence. By superior intelligence we mean those women who received an I.Q. of 120 or above on a standardized scale for the measurement of intelligence. The mean of this group was 120.5. The scores obtained are reported in the following table.

TABLE II.

I.Q. AND INCIDENCE AMONG ONE HUNDRED PSYCHOTIC WOMEN
OF SUPERIOR INTELLIGENCE

Score-Number		Score-Number		Score-Number	
120	50	126	10	133	1
121	2	127	3	134	2
122	6	128	1	135	2
123	2	129	5	138	1
124	2	130	6	140	1
125	10	131	2	170	2

Grouping these scores we find that they fall into two classifications

TABLE III.

CLASSIFICATION OF ONE HUNDRED PSYCHOTIC WOMEN
OF SUPERIOR INTELLIGENCE

Score	Number	Classification
120 - 127	78	Superior
128 - and above	22	Very Superior

There is no way of knowing to what extent, if any, there has been deterioration in the capacity of these women of superior intellectual capacity. Roe and Shakow found in a study of unselected patients in a State Hospital that "intellectually there is relatively little disturbance." In the same report they mention that schizophrenic patients are most affected on tests involving conceptual thinking. Binet and Simon (1916) early observed "it is almost an absolute rule that the insane undergo a lowering of level." We have made many advances in psychometrics since that time and the more recently developed tests given under controlled conditions yield scores which are comparable and able to show a more refined differentiation than the earlier tests. Hart and Spearman in a pioneer correlation study found in the various types of psychoses little damage of specific functions but a marked general lowering of intellectual level. Roe and Shakow reported from study of Intelligence in Mental Illness made at the Worcester State Hospital that "In most of the psychoses and psychopathies, we found deviation from normal functioning, which however, varied considerably in degree from one type of disorder to another. These deviations were of two sorts; a general lowering of performance and a more marked lowering in some types of tests than others."

These women endowed with superior intellectual ability were studied to learn if their scholastic achievement corres-

ponded. The individual case histories indicate that there were many factors which interfered with their attaining the high educational level of which they were potentially capable. The economic status of the family, cultural patterns of parents recently admitted to this country from Europe which did not recognize the need for higher education for girls were among the leading reasons given. The scholastic level is reported in the following table.

TABLE IV.

SCHOLASTIC ACHIEVEMENT OF ONE HUNDRED PSYCHOTIC WOMEN
OF SUPERIOR INTELLIGENCE

Scholastic Level	Number
Elementary School	4
High School - 1 year	8
High School - 2 years	2
High School - 3 years	3
High School - 4 years (Graduated)	19
College - 1 year	13
College - 2 years	17
College - 3 years	1
College - 4 years (Graduated)	30
Graduate - Master's degree	3

All but two of the women were described throughout their school life as "above average" or "superior" students. According to Carroll:

Gifted children as a group are characterized by the following mental qualities; power, broad attention span, alertness, keen observation, curiosity, self criticism, a sense of relative values, initiative, and insight into relationships.

One impressing aspect of a gifted mind is tremendous energy. A bright individual possessing this vital mental energy approaches a problem with a steady and assured attitude.¹

Carroll believes that "second in importance to intelligence among factors which make for great success is a quality known as drive; the source of the drive is varied, differing not only among individuals, but also within individuals." There is mention of this characteristic in the record of the majority of the women studied. However, they appeared to lack "the sense of relative values," and "insight into relationships" for they exhausted themselves because of this drive to activity. Here, as in all matters, the goal of the activity and the purpose play an important part in evaluating this force as constructive. From the histories we learn that as the illness developed this drive was modified. A common symptom of mental illness, excepting manics, some paranoids, and psychopathic personalities is the lack of energy. Roe and Shakow found in their study that the schizophrenic's behavior seems "less goal-minded than the normal; as is seen in the more frequent failure to complete tasks which have been interrupted, and a tendency to self-interruption of tasks." Fifty-six of the women studied are diagnosed as dementia praecox (schizophrenia,) and four have a diagnosis of manic depressive, depressed, which is also an enervating men-

¹ Herbert A. Carroll, Genius in the Making, p. 117

tal illness. Thus sixty per cent of these women were apparently slowed down by the mental illness.

There is a marked relationship in the occupational level with the educational attainments. Thirty-nine of these women including the thirty-three who completed college and earned a master's degree were engaged in work on a professional level. However, the three women employed as domestics had an I.Q. of 125, 127 and 130. Two of these were from families with foreign cultures in which higher education for women was opposed; and the third has a diagnosis of psychosis with psychopathic personality. Her psychopathology was apparent during adolescence. Four of the women studied had never been given any responsibilities in the home and had had no work experience outside of the home. The women were engaged in the following types of work which have been combined with the Minnesota Occupational Classification in the following table.

TABLE V.

OCCUPATIONS AND OCCUPATIONAL CLASSIFICATION OF ONE HUNDRED PSYCHOTIC WOMEN OF SUPERIOR INTELLIGENCE

Occupations and Occupational Classification		Number
I. Professional		39
Artists	4	
Journalists	1	
Nurses	2	
Librarians	2	
Musicians	4	
Social Workers	3	

Teachers	23	
II. Semi-professional and managerial		--
III. Retail business, clerical and skilled trades		24
Book-keeper	4	
Comptometrist	1	
Secretary	11	
Stenographer	8	
IV. Farmers		--
V. Minor business, semi-skilled		30
Beautician	2	
Clerical	8	
Dressmaker	1	
Factory Worker	4	
Homemaker	7	
Telephone operator	1	
Waitress	7	
VI. Slightly skilled		3
Domestics	3	
VII. Unskilled		-

A number of women became acutely ill but for the majority we find that the personality and ability were affected for many years prior to admission to a mental hospital. This effect is reflected in the progress or achievement of the job itself. One woman with an I.Q. of 129 was employed as a laundress for ten years; several with ratings of Very Superior intelligence held only minor clerical jobs. One patient with an I.Q. of 129 with a good position and a promise of advancement gave up her work because she said she "was paid too much" and took a clerical position requiring minimal ability.

It is striking that difficulty in getting along with vocational associates and supervisors is the highest ranking vocational problem. Intelligence is but one of the determiners of success. Psychiatrists have long been impressed with the departure of the neurotic and psychotic person from dependability in mental performance.

Intelligence is an important part of the social personality pattern. Social intelligence is thought of as ability to get along with people, of being happy and comfortable with them, of being liked by them and rarely coming into conflict with them. We find in the history of these women that this quality is distinctly lacking in the majority. Emotional stability which is essential for making and keeping friends does not always necessarily go with high intelligence. In childhood we find the majority seclusive, satisfied to play alone and unable to play with children of both sexes. This is also a characteristic of the unusually bright child and does not necessarily indicate a neurotic trait.

In the ultimate expression of sociability in marriage we find that many were unsuccessful. Forty-nine of these women have never married and many of them never had boy friends. From statistics we learn that the percentage of certifiable psychoses is greater among the unmarried than the married. This condition obtains in this study. The higher percentage of dementia praecox in the single group

is confirmation of the concept of this disease that considers it a serious defect in capacity for biological adjustments. The women had many unresolved fears, anxieties and insecurities about sex, their own sexuality and their husband's. Few had acquired a conception of sex as a normal part of every one, which is continuous throughout life and has to be dealt with at different stages of development in different ways. A few had suffered some kind of traumatic sex experience as children which seemed to leave a residue that was carried over into adult life.

TABLE VI

SOCIAL STATUS OF ONE HUNDRED PSYCHOTIC WOMEN OF
SUPERIOR INTELLIGENCE

Social Status	Number of Women
Single	49
Married	32
Widowed	9
Divorced	7
Separated	3

In regard to problems of physical health the findings of this study agree with those of Dr. Leta Stetter Hollingsworth and Herbert Carroll. They mention that nearly every aggregation of data on the subject of health among gifted children show them to constitute an unusually healthy group. Most of the women had the childhood diseases and many had operations but on the whole they were exceptionally healthy. For only two women has

physical health been a major problem. One of these was found to have active tuberculosis at the time of admission and was transferred to a sanatorium. The other is the woman reported in Case Study III.

Religious problems were less common than any other, with the exception of health, or else they were expressed less frequently. These women learned their religious beliefs and practices from their parents. During their early years they were concerned primarily with their obligation to conform to the parental ideas which built up some resentment. The discovery at college or when leaving home of different religious values brought some confusion and conflict. At maturity some continued the earlier practices and beliefs while others rejected them with obvious feelings of guilt. It was at the time of marriage and following the birth of children that most concern was expressed. This centered around the philosophy and ideals which should be taught their children. The women for whom religion became an important problem were the Catholic women who married Protestant men. Since the three Jewish women were single nothing is known of conflicts that a mixed marriage might have brought to them. Sixty-four of the women were Protestants, three were of the Jewish faith and thirty-three were Catholic.

There is some significance in the fact that only one of these women, Julia, was at any time brought into court

charged with misdemeanor or crime. These findings agree with those of Hollingsworth who reports, "Among juvenile offenders in children's court and in correctional institutions children of superior intelligence are rarely found." She found that juvenile delinquents show a mean I.Q. well below 100, with very few cases reaching higher than 115. Burt points out in The Young Delinquent, that the "presence of intellectually gifted children in a delinquent group is an exception." The consensus of opinion is that the individual of superior intelligence rarely develops anti-social tendencies. On the contrary, they are among those who uphold and defend society.

The study did not reveal that the superior intelligence played any part in bringing on or delaying the onset of mental illness. A review of literature does not furnish any information either. The age range is from 18 to 70 years with the medium age at thirty-four years and six months. The age at the time of admission is reported in the table below.

TABLE VII

AGE OF ONE HUNDRED WOMEN OF SUPERIOR INTELLIGENCE
AT THE TIME OF ADMISSION

Age	Number	Age	Number	Age	Number
18 -	4	32 -	2	48 -	2
20 -	1	34 -	1	49 -	1
21 -	6	35 -	1	50 -	2
22 -	2	36 -	6	52 -	1
23 -	1	37 -	2	54 -	3
24 -	4	38 -	5	56 -	2

26 - 4	39 - 2	61 - 1
27 - 4	40 - 5	62 - 2
28 - 8	41 - 3	63 - 3
29 - 3	42 - 2	64 - 1
30 - 7	43 - 1	66 - 2
31 - 5	47 - 2	70 - 1

Although it is recognized that early diagnoses may reduce the period of hospitalization we find that improved methods of treatment are also a factor in shortening the period of hospitalization. Electro-shock and insulin shock materially have been particularly effective. Trial visits under supervision of the Social Service Department also provide facilities which make it possible for individual patients to return to the community sooner than was possible before mental hospitals recognized the part Social Service could play in the rehabilitation of patients. The median period of hospitalization is between four and five years.

TABLE VIII

TIME OF HOSPITALIZATION FOR ONE HUNDRED PSYCHOTIC WOMEN
OF SUPERIOR INTELLIGENCE

Hospital Age	Number of Women
Less than 6 months	23
6 months to 1 year	-
1 year to 2 years	10
2 years to 3 years	9
3 years to 4 years	7
4 years to 5 years	1
5 years to 6 years	6
6 years to 7 years	3
7 years to 8 years	2
8 years to 9 years	3

9 years to 10 years	2
10 years to 11 years	3
11 years to 12 years	5
12 years to 13 years	1
13 years to 14 years	4
14 years to 15 years	1
15 years to 16 years	2
16 years to 17 years	1
17 years to 18 years	3
18 years to 19 years	4
19 years to 20 years	3
20 years to 21 years	1
21 years to 22 years	1
22 years to 23 years	-
23 years to 24 years	-
24 years to 25 years	2
25 years to 26 years	-
26 years to 27 years	-
27 years to 28 years	2
28 years to 29 years	1
29 years to 30 years	1

The present emphasis of individual treatment of mental patients provides for a review of progress at intervals. When it is found that the patient has improved she is released to responsible relatives on trial visit; sometimes this state is described as parole. Many states do not use the term parole because of its connection with penal institutions. If conditions do not permit the patient to maintain the remission or if the illness is one in which deterioration can be expected the patient may be re-admitted. In studying the case histories of these women we find that there has been only one admission for 57 of them. The manic depressives and some dementia praecox patients attain remission and are discharged on trial visit. We believe that this period of family care even

for a few months provides a happier life for the patient and enables the State Hospitals to use this therapeutic method of relieving the crowded conditions. The number of admissions is reported in the following table.

TABLE IX

SHOWING THE NUMBER OF ADMISSIONS OF ONE HUNDRED
PSYCHOTIC WOMEN OF SUPERIOR INTELLIGENCE

Number of Admissions	Number of Women
1	57
2	15
3	13
4	7
5	3
6	2
7	3

The present status of these women is reported in the following table.

TABLE X

PRESENT STATUS OF ONE HUNDRED PSYCHOTIC WOMEN
OF SUPERIOR INTELLIGENCE

Present Status	Number of Women
Hospitalized	54
On Visit	12
Discharged	31
Deceased	3

Those patients on trial visit have recovered to the extent that the psychiatrist believes they can adjust in their

former home or a foster home.

The Massachusetts Department of Mental Health defines the trial visit as . . . "a discharge to relatives or friends who agree to assume financial support and care with the understanding that if the patient remains outside the hospital for one year the visit becomes an absolute discharge. During the year the patient may be returned at any time to the hospital without commitment . . . in this way the relatives are able to keep the patient in their home and if the patient is mentally disturbed he may be returned to the hospital without a new Court Commitment." 2

The twelve women on visit are under the supervision of a psychiatric social worker. At this time two of these women are employed, one is studying and preparing to enter a field of work less strenuous than that in which the mental breakdown occurred. Eight of them have resumed the responsibility for their families; and, one is at home against advice and is unemployed. In this era of social psychiatry the psychiatric social worker plays an important part. The sound practice in the state hospitals of placing carefully selected patients in foster homes or in their own homes provides a happier life for the patient and is less expensive to the State.

2 Department of Public Welfare, Manual of Laws, Rules, Policies, and Procedures for the Administration of Public Assistance, September 1939, Revised May 1 941, Chapter VI, p. 7.

CHAPTER III

HEREDITARY FACTORS

Biologists and psychologists mean by "hereditary" the process whereby the traits and capacity of an organism are derived and determined by ancestral germ plasm. In this study the writer was able to secure information regarding the mental health and incidence of diagnosed mental illness of the grandparents, parents and parental siblings in addition to the patient's siblings. In a few cases where the grandparents or parental siblings were residents of foreign countries the information may be less accurate than that obtained of relatives living in this country. As Allport reminds us, "The doctrine of hereditary determination does not state that personality is inherited, but rather no feature of personality is devoid of hereditary influence." Huntington's Chorea is one of the few conditions strongly suggesting the Mendelian pattern. Most psychologists and psychiatrists believe that heredity is not an important factor in mental illness except in the manic depressive (cyclothymic) group. This mental disorder does suggest an hereditary factor.

When evaluating hereditary factors many psychologists and psychiatrists agree with Dr. William A. White who believes:

The whole subject of heredity, so far as it relates to insanity is in a most unsatisfactory state, very largely because investigators have been dealing

with "insanity" as if it were a simple concrete affair instead of the complex thing that it has proved to be. . . . An inherited predisposition to mental disorder is found in from 30 to 90 per cent. But any one who is at all familiar with the collection of statistics must know how impossible it is for them to fully represent the facts in such a manner. ¹

In the same text he continues:

In dealing with the subject of heredity, however, it must not be forgotten that our ideas are of necessity largely founded upon hypothesis, as biological science has not yet unfolded a sufficient number of facts to make it possible for us to tell just how much in any individual case, must be attributed to the inherent qualities of the "germ plasm" and just how much to the influence of the environment. ²

Dr. Edward Strecker calls attention to the dynamics of personality development which requires recognition of the continuous change. In this manner Dr. Strecker brings into focus the theory of hereditary and environmental influences at the same time. He writes:

In teaching I have utilized the following hypothesis; At birth each individual is provided with a zone of defense against the development of mental disease. The amount of thickness of this zone of resistance varies by reason of the assets and liabilities derived from inheritance. From the instant of birth the amount of resistance constantly changes, increases or decreases, according to the experiences in life, somatic and emotional, and the reactions of the total personality to these experiences. Should these experiences be very severe or should destructive happenings follow each other in close sequence, then there is grave dan-

1 William A. White, An Outline of Psychiatry, p. 16.

2 Ibid., p. 17.

ger that the wall of resistance may become perilously weak, so that a trivial untoward circumstance may seem to precipitate a major or minor psychosis. ³

This is simply a scientific way of expressing the folk doctrine of the last straw that broke the camel's back. The writer was interested to observe that the majority of texts studied and listed in the Bibliography did not mention "heredity" among the indexed subjects.

This study revealed that ten grandparents and nineteen parents of these women had a diagnosed psychosis. In all there were fifty-nine individuals within the immediate kin who were mentally ill. This number does not include those relatives who were described as rigid, heavily alcoholic, "queer" or who had a nervous breakdown." One woman had three siblings in another mental hospital and another patient had two sisters who were mentally ill. The remainder had only one relative. The incidence of mental illness among relatives is reported in the following table.

TABLE XI

INCIDENCE OF PSYCHOSIS AMONG RELATIVES OF ONE HUNDRED PSYCHOTIC WOMEN OF SUPERIOR INTELLIGENCE

Relationship	Number
Paternal grandfather	2
Paternal grandmother	3
Maternal grandfather	2

³ Edward Strecker, Fundamentals of Psychiatry, p. 16.

Maternal grandmother	3
Paternal siblings	9
Maternal siblings	6
Father of patient	7
Mother of patient	12
Siblings	15

To many this suggests that such heavily loaded families must of necessity have transmitted the psychosis directly to the women while others would limit the contribution to a predisposition towards personality disorder. Studies in human heredity are most often reported in statistical form and limited to a particular disease. Since we do not know the medical diagnosis of all these relatives it is not possible to make a comparison with the data available. Ssucharewa reports an hereditary taint in 85 per cent of thirty-five schizophrenic children and Ruden states "that the more heavily the familial background shows schizophrenia, the more likely the disorder is to appear in childhood."

Others believe that the personal influence of a psychotic parent may be as deleterious to the maladjusted child as are the hereditary traits which are transmitted. Dr. Lauretta Benda has been strongly impressed with the parental influence upon child behavior and adjustment. She observed, "Mental and emotional retardation occurs in children who are confined with defective and schizophrenic parents, and are deprived of the normal environmental stimuli for growth, especially language development in the early years." In this same con-

nection, Annet Garrette counsels, "Mental breakdown is often thought to be hereditary when it may rather be in large part the results of environmental pressure. Childred exposed to environmental tensions created by the presence of a psychotic parent, or the insecurities engendered by his absence in a hospital need special protection and understanding care to help them attain a healthy adjustment." The thumb-nail reports of mental illness in the home of three patients suggests the strain and stresses such association brings to bear on the sensitive developing girl.

Beatrice's mother was committed to a State Hospital with a diagnosis of dementia praecox, paranoid type when Beatrice was 13 years of age. Our patient's history reveals that she was a behavior problem from early childhood; a prevaricator, and such a disturbance at school that she was suspended many times. Her father, conscious of the difficulties his wife's illness made for his daughter, indulged her in every wish. She was not disciplined for any misbehavior though there were many incidents of a serious nature. In early adolescence she showed Lesbian tendencies. Her diagnosis is manic depressive, manic.

Alice who is a graduate magna cum laude of one of the Eastern Colleges with high scholastic standards has been hospitalized for nine years. Her father died of a brain tumor when Alice was nine years of age. Her mother was admitted to

a mental hospital with a diagnosis of manic depressive, depressed when Alice was sixteen years of age. Alice, her younger sister, and two brothers lived with an older married sister until they completed their education. This older sister was said to have had a psychopathic personality. From this history we learn that there was little family coherence even before the home was broken up at the time of the mother's admission to a mental hospital, and it is not surprising to read further that after her two brothers completed college they moved West and nothing has been heard of them in the past twenty years.

Catherine who is the youngest of seven siblings had a mother who was committed to a mental hospital when she was thirteen years of age. Prior to the mother's commitment the patient and her siblings were said to have been affected by the friction in the home due to their mother's "nagging, fussing, and extremely nervous condition." The mother's diagnosis is dementia praecox, paranoid type while the diagnosis for Catherine is psychosis with psychopathic personality. Alice had three siblings who were admitted to mental hospitals and an alcoholic brother.

The influence of parents who were psychotic can be more directly studied and evaluated as a contributory factor than that of other relatives unless they were members of the household group. The illness of the mother is of primary im-

portance since much of the training is left to her. Where there is a neurotic or psychotic mother she will be unable to establish an orderly routine in the home, set up dependable and predictable methods of discipline, manage the meals and housework, and supervise the establishment of desirable extra-familial social activities. Mental illness in the family, particularly of the parents arouses feelings of extreme anxiety, of shame and insecurity. The writer found that mental illness in a family tends to bear most heavily upon the adolescent daughter.

The material in this study can be interpreted by either group. Those who hold to the inheritance factor per se may see in the study the direct inheritance of the psychosis while those who doubt that heredity plays such specific part will see the incidence of mental illness among relatives as an added influence in the environment of a constitutionally weakened individual. A close study of the histories of these women suggest that the aberrations of mood and behavior and even the mental illness can not be ascribed to hereditary factors alone. In this study the writer found that the majority are of the same opinion as Rosanoff who believes that "more often it appears that hereditary factors determine a more or less marked position towards certain mental disorders and the actual breakdown is brought about by postnatal factors." This belief appears sound and applicable to the

women of this study. While the degree to which each of these psychotic women inherited the mental illness is problematical there is little doubt that they were harmed by the association and mistreatment accorded them because of the parent's mental illness. Writing in a descriptive manner Hendricks says, "Heredity is the flour and water of human nature, emotion is the yeast, environment is the baker; and the mixing bowl and oven are the earliest years of life."

When considering the environmental factors which may be contributory to the development of mental illness of these and similar cases, these factors which the patient are exposed to include all factors which are general and personal. Under general we consider the social setting, the adequacy of housing, type of neighborhood, and economic status of the family. In this study we find that no problems related specifically to the physical environment with the exception of inadequate income in five families. But, we find in these same homes alcoholic fathers and coercing fathers; and, it is impossible to determine which conditions resulted in the greatest harm for the growing girls. Of the one hundred women studied thirty grew up in comfortable circumstances, sixty-five lived in homes of var-

CHAPTER IV

ENVIRONMENTAL FACTORS

From a textbook on Clinical Psychiatry we learn that:

Environmental factors are of great importance. Evolution and the progress of civilization has introduced complexities which probably serve to weaken resistance against mental disease. Civilization has great advantages but it does tend to make more difficult and places inhibitions in the way of a satisfaction of natural instincts. Furthermore, environment also must be considered in its more personal relations. Defective training in childhood is a poor preparation for the battle of adult life and no doubt many an individual gives up the struggle and sinks into unreality or insanity because he has not been prepared and the odds are therefore too great.¹

When considering the environmental factors which may be contributory to the development of mental illness of these one hundred women those factors which lie outside the patient are both general and personal. Under general we consider physical setting, the adequacy of housing, type of neighborhood, and economic status of the family. In this study we find that no problems relate specifically to the physical environment with the exception of inadequate income in five families. But, we find in these same homes alcoholic fathers and deserting fathers; and, it is impossible to determine which conditions resulted in the greatest trauma for the growing girls. Of the one hundred women studied thirty grew up in comfortable circumstances, sixty-five lived in homes of mar-

¹ Strecker and Ebaugh, Clinical Psychiatry, p. 37.

ginal incomes and only five families required some form of public assistance.

Kanner believes that "the home looms foremost among situational factors which contribute to the molding of the child's personality." He points out:

That the first fundamental period of childhood, that of elementary socialization, takes place entirely in the home, and that the second period is essentially one of progressive domestication, ushering the child into the ultimate task of communal adjustment. The specific form which this gradual maturation assumed in the individual child will therefore depend not only on his own constitutional endowment but also to a large extent on the influences, examples, and standards of the milieu in which he spends the years of his greatest plasticity and impressionability. Realization of this fact will guard against the total neglect of that which the individual brings with him, his inherent capacities, and limitations of a physical, intellectual, or adaptive nature; it will cause us to accept Stern's "theory of convergence," stating that both predisposition and environmental factors must work together in order to establish a particular mode of re-action tendency. ²

In Lowrey's Psychiatry for Social Workers we learn that:

Early environmental influences, are, as is well recognized, of great importance in shaping personality, determining the direction or development and the manner in which the instinctive drives are integrated into a smoothly functioning whole. There, the history of the immediate family, its organization and status is very important. The attitudes of the members of the family group towards each other and towards the outside world in all its combinations are of special signification. ³

² Leo Kanner, Child Psychiatry, p. 87.

³ Lawson G. Lowery, Psychiatry for Social Workers, p. 16.

Both psychiatrists are emphasizing the importance of the interpersonal relationships. For the sake of organization of material the writer in this study grouped the problems arising in the interpersonal relationships with those found in the parental relations and indirectly reflecting in absorbed attitudes and disposition on the part of the patient; those found in the child-parent relationships, and those arising in the intersiblingship. Harmonious family life is one of the best guarantees of the smooth adjustment of the normal girl and for her optimal adjustment emotionally and intellectually. Twenty-four of the women studied believe that they had a normal relation with both parents. The study of home conditions reveals that the problems, the conflicts, dissatisfactions and inadequacies of the parents were reflected in the child. Parental friction with the attendant quarreling and unhappiness is reflected in the entire home atmosphere. (These conditions can bring about a change in attitude from healthy respect for the parental authority to dread and contempt.) Parental alcoholism, desertion, poverty, and conflicts arising out of personality inadequacies of parents, and of religious and cultural differences and mental illness are prominent. As described in the table below, forty-two parents were out of the home by reason of death, desertion, separation, or admission to a psychopathic hospital.

TABLE XII

PARENTAL PROBLEMS OF ONE HUNDRED PSYCHOTIC WOMEN
OF SUPERIOR INTELLIGENCE

Problem	Number
Death of father	9
Death of mother	9
Father deserted	2
Psychotic father	7
Psychotic mother	12
Alcoholism	11
Poverty	5
Cultural Patterns	6
Parental friction	32
Broken homes	3
None reported (unknown)	4

We recognize that personality disorders may arise from the interruption of the normal home life through the death of a parent, desertion, or from the fact that a parent has been admitted to a psychopathic hospital. In the case of desertion or separation where the home is broken up usually a long period of domestic unpleasantness precedes the breaking up. The final disintegration is the outcome of many years of non-integration. Needless to say, many women from broken homes present no particular behavior problem or emotional disturbance. Much will depend on the girl's own make-up, and the circumstances preceding, accompanying, or following the separation. Professor Landis and Marjorie Bolles in Sex and Development demonstrated that emotionally insecure

homes were more common among those individuals who developed mental diseases in adult life than in those who were mentally normal. When it is evident that strained relations between the parents affect the child, directly or indirectly, so that a personality disorder develops, one can expect that the faulty relations between the child and his parents will be of even greater significance in the formation of his character, his habits, and his attitude. These illustrations of problems of parents which affected the stability of the growing girl, her attitude and interests are representative of these found in this study.

Mary's father was said to have been cold, aggressive and stubborn. He regarded himself as important and considered his wife and daughters as worthless; and, was strict and selfish in his relations with his family. He ridiculed his wife who was well educated and of a stable personality. From this family we have not only the tragedy of her mental illness but her 11 year old brother hanged himself when Mary was 13 years of age.

Anne grew up in a home where her parents were of different nationalities. The culture in which a child grows up influences his behavior both in mental health and mental illness. The father was strict, had a violent temper and frequently threatened the family if they did not give in to his demands. According to the custom of the country of his na-

tivity he expected his children to turn over their earnings to him and this brought about much resentment on the part of his children. The mother who was sixteen years younger than her husband was weak-willed and unable to protect herself or the children. It is interesting to note that in accord with her general nature she was pregnant at the time of her marriage. Later, Anne's father was committed to a state hospital. Other family difficulties relate to personality abnormality of the oldest son and a sister who had tuberculosis of the hip.

June's parents were of different religions; her father was a Protestant and her mother Catholic. Her mother gave her children inadequate care and abused them. June's father died when she was two years of age and shortly afterwards her mother married a younger man. They were not congenial and were divorced. Within a year June's mother was admitted to a state hospital with a diagnosis of schizophrenia, hebephrenic type. This occurred when our patient was six years of age. She was then taken by a paternal aunt who supervised her closely and provided strict religious training. June was not allowed to bring her friends to the home or to have any association with boys. She was forced to stop school and go to work at 14 years of age. She expressed early fears of "insanity" because of her mother's illness.

In Emily's home her parents would not speak for days.

Most parents do their jobs well with a full realization that the child must be fed, clothed, educated properly; and, encompassed with protection and such feelings of security that enable her to develop feelings of responsibility of her own in due time. As Kanner says, "It is the parents who domesticate the child and prepare (her) for communal socialization."

Behavior disorders usually arise from three main types of parental aberration from the normal and desirable relationship; (1) parental over-indulgence and over-protection; (2) parental indifference and neglect; (3) parental hostility and rejection. The over-solicitous parent keeps the child from growing up. As a result, these children never learn the value or meaning of self-responsibility and independence. They remain infantile in their behavior. It is interesting to observe that over-indulgent parents may at the same time be the nagging scolding parents. This inconsistency, the child fails to understand. He is not able to handle it in a normal and acceptable way so that it can not fail to have damaging effects. We find that the personality difficulties of sixteen women of this study were directly connected to these abnormal and unsatisfactory child-parent relationship. Nine of them suffered from indifference and neglect; one of these parents was also demented. Thirty-two felt that they were rejected by one or the other parent and another sibling

preferred. Thirty-four women of this study were attached to one or the other parent. This over-attachment interfered with the normal heterosexual adjustment.

From the histories we find that unhealthy conditions were present and their affect noticeable in the early years. One of the prominent psychic manifestations in childhood is that of identification with the parents and the dissolution of this identification in the development of the individual's ego. Helene Deutsch brings this out in her Psychology of Women. She writes:

In discussing personality formation...we shall turn our attention again and again to the problem of identification. The weaker the child's ego, the more it resorts to identification with adults in its adjustment to the adult world. We often make the mistake of assuming that the identification with the mother makes for "femininity" in the child's personality, and identification with the father for "masculinity." We tend to forget that in the wide range of child-parent relationships developed in the course of childhood there is no one single consolidated idea of the mother or the father. There is a beloved mother and a hated mother; a sublime ideal mother and a disreputable sexual one; a mother who has castrated the father and another who has been castrated by him; one who bears children and one who kills them; one who nourishes them, another who poisons them; there is the rival, and the personification of security and perfection...The way in which the child resolved its conflicting feelings of ambivalence in earlier periods is also important. Much depends on whether identification with the loved object is possible or whether the intensity of the child's own aggressive and intensive guilt feelings drive him or her to identification with a malign, punitive, suffering or even dread object.

Each of these possibilities becomes stronger in this period (puberty) of active searching for methods of

strengthening the ego and influences the character of the child's prepuberty. Simultaneously, the tendency to abandon earlier identifications becomes noticeable. The young girl begins to be extremely critical of her parents and particularly of her mother; she develops a very realistic approach to the outside world, gives up her infantile overestimation of her parents, and frequently makes energetic attempts to be different from her mother.⁴

Much of the quality of a personality depends upon an emotional attachment to the mother.

In Table XIII we summarize the problems found in the child-parent relationship of the women studied.

TABLE XIII.

PROBLEMS IN THE CHILD-PARENT RELATIONSHIP OF ONE HUNDRED
PSYCHOTIC WOMEN OF SUPERIOR INTELLIGENCE

Problem	Incidence
Over-indulgent and over-protective	16
Indifferent and neglectful	9
Hostile and rejective	32
By father	14
By mother	18
Overattachment of parents	34
To mother	11
To father	23

Sometimes the specific type of association with siblings may contribute its share to the development of personality problems. From the histories of these women we find that thirty-six of them reported a good sibling relationship. Some of these were the oldest and some the youngest so it

⁴ Helene Deutsch, Psychology of Women, Vol. 1, p. 7.

is not known whether by virtue of position they were favored and for this reason lacked complaints which a sibling might have found to exist. Twenty-eight of them were keenly affected by unfair situations which aroused jealousy and sibling rivalry. Resentment and friction for a number of them was created by the parents' preference of one child to the patient. Generally, both children are harmed by such practice. Not a few cases of sibling hatred date back to unequal treatment of childhood. A certain amount of difference is to be expected but when this condition becomes colored with highly emotional content, feelings towards parents and/or siblings becomes abnormal. Regardless of the unwillingness of parents to recognize jealousy in their children as a normal reaction this trait

stands out prominently as the cause of much unrecognized conflict in early life and from a social point of view is very important. Not only does it stimulate anger, hatred and inferiority in the child, but in later life it may influence conduct so that the individual is continually at odds with his environment. ⁵

Seventeen of these women studied were only children. Many only children develop healthy personalities with wise management. There is more likelihood that an only child will be over-indulged and over-protected by an over-solicitous mother or parents. This is particularly true where the

⁵ Douglas Thom, Everyday problems of the Everyday Child, p. 168.

single child is the result of death of other siblings. The specific difficulty for five of these women occurred following the death of their father. The lonely mother in each instance gave her daughter an over-abundance of emotional mothering and over-solicitation. There is nothing in the history of the remaining twelve only children to indicate that being an only child was responsible for any emotional traumas. We have no specific information regarding relationships with siblings for eight women that could be construed as favorable or unfavorable in their development. This fact of itself may have significance. The problems are summarized in the following table.

TABLE XIV.

PROBLEMS ARISING FROM SIBLING RELATIONSHIP AMONG
ONE HUNDRED PSYCHOTIC WOMEN OF
SUPERIOR INTELLIGENCE

Problem	Incidence
Sibling rivalry	28
With brother	14
With sister	14
Psychosis of sibling	10
Alcoholic sibling	3
Sibling ran away from home	3
Only child	17
Unknown	8

Steps taken to bring about the socialization of a child with his parents, siblings and other relatives can not be started too early. One of the best criteria of social nor-

malcy is pleasant relationship with immediate kind and mate. The prevention of anti-social and unsocial contacts has to begin ipso facto with the child's relationship to her parents, her brothers and her sisters. The crux of the home is the adjustment of the parents and the security and love which they are able to provide their children.

for each of these cases. In addition to an adequate medical social history, a hospital record, three psychometrics- The Wechsler-Bellevue, the Early Picture Completion Form II, and the Bell Adjustment Inventory; the writer was able to observe and interview each patient. Identity of each woman has been carefully retained and other identifying data changed or omitted. The information regarding early development as reported by mother and verified, and the hospital data are accurately reproduced.

Case Study I

Julia has a diagnosis of psychosis with psychopathic personality though there have also been diagnoses of manic depressive, depressed, primary behavior disorder, simple adult maladjustment; schizoid personality without psychosis, psychopathic personality. She has an I.Q. of 170 which places her in the 99th percentile.

The family history may be described as contributory. The paternal grandfather was a successful business man who died of coronary thrombosis at the age of 66 in 1932 following a visit to Julia's father who was a patient in a private mental hospital. The paternal grandmother was a patient in a private mental hospital at the age

CHAPTER V

CASE STUDIES

The case histories were selected to illustrate the influence of hereditary traits as found in immediate antecedents and environmental stresses which are evaluated as contributing factors in the development of the psychosis for each of these women. In addition to an adequate medical social history, a hospital record, three psychometrics- The Wechsler-Bellevue, the Healy Picture Completion Form II, and the Bell Adjustment Inventory, the writer was able to observe and interview each patient. Identity of each woman has been carefully disguised and other identifying data changed or omitted. The information regarding early development as reported and verified, and the hospital data are accurately reproduced.

Case Study 1

Julia has a diagnosis of psychosis with psychopathic personality though there have also been diagnoses of manic depressive, depressed; primary behavior disorder, simple adult maladjustment; schizophrenia; without psychosis, psychopathic personality. She has an I.Q. of 170 which places her in the 98th percentile.

The family history may be described as contributory. The paternal grandfather was a successful business man who died of coronary thrombosis at the age of 69 in 1932 following a visit to Julia's father who was a patient in a private mental hospital. The paternal grandmother was a patient in a private mental hospital at the age

of 17. She is now 70 years of age and in good health. The family lawyer describes her as "dominating- ruling the family with an iron hand; and definitely not the quiet old lady type." Patient's father who was born in 1900 is the younger of two siblings. He attended private schools but due to indifference and lack of application did not graduate. He has been drinking heavily since the age of 19. His father took him into his business at the age of 20 when he married Julia's mother. Following his divorce from our patient's mother he married a "gold digger" and chorus girl against his parents' wishes and was subsequently divorced. He has been in and out of private mental hospitals and penal institutions during the past 16 years. The psychiatric diagnosis is chronic alcoholism with deterioration; psychopathic personality. Julia's association with her father has been limited to a few times when he was in his parents' home during the time of her visits. She has expressed herself as being fond of him and sorry for him.

The maternal grandfather is a business man, 75 years of age and in poor health at this time. He is kind, soft-hearted, peaceful, and has always been over-indulgent to Julia's mother and to her. The maternal grandmother, age 70, is loving, sympathetic and over-indulgent. They are described as a socially elite family. The paternal grandmother denies any friction between the families but the maternal grandmother acknowledges open hostility. Julia's mother was born in 1900, was an only child, loved and indulged. She had Sydenham's Chorea at nine years and was always highly nervous and temperamental. She married at twenty- was extravagant and alcoholic at the time. Following her divorce when Julia was fourteen months old she returned to her parents' home but at no time assumed the responsibility for her daughter's care and training; and she was never affectionate with Julia. In 1924 when Julia was two years old her mother threw herself in front of a train in a suicidal attempt. In this attempt her left foot was amputated. Later, she married an extremely wealthy, and alcoholic man and moved to New York leaving Julia with her parents. In 1938 when Julia was 15 years of age she committed suicide by jumping in front of a

subway train.

Julia was born November 26, 1922 and weighed ten pounds at birth. Her mother drank and smoked excessively while carrying patient. During infancy this child was given over to nursemaids and her mother showed little interest in her. Following her parents' divorce when she was fourteen months old Julia was taken to the home of her maternal grandparents. They "adored her, spoiled her, and waited on her hand and foot." During childhood she had three of the childhood diseases without complications. She had a tonsillectomy at ten years and there were no other operations or injuries. Julia has been in good health all of her life and always overweight. She weighed 120 pounds when ten years old and was the laughing stock of the neighborhood. Julia's maternal grandparents told the writer that she was a likeable docile child and easily pleased, and that she spent much time by herself as she did not make friends easily. Her paternal grandmother said that she bit her nails, had strong likes and dislikes, peculiar food habits and an enormous appetite. She could be sulky and was always independent and did not take anyone into her confidence. She was never an affectionate person. No masturbatory or unconventional sex habits were observed. Julia was a quiet child and read a great deal. Because of her lethargic state she was never active in sports. Her mother married a second time when our patient was four years old and moved to New York. After that Julia divided the time between the homes of her grandparents and continued to live between the two families until she entered a private academy at the age of thirteen with the exception of her tenth year. She spent that year with her mother and step-father in New York and has often said that it was the happiest year of her life.

By the latency period we see that Julia had already established neurotic reactions to the problems of her family relationships and environment. She had never had the security of being a permanent member of a family group. In her early

childhood she experienced fears of not being loved and of desertion which English and Person say have a "deleterious effect on the development of the (girl's) personality and is likely to produce an illness." We may assume that Julia's desire for extra food was an attempt to satisfy her longing for the love of her mother.

When Julia entered the Academy the teachers found her likeable and a good student and "thought that she was well liked by her fellow students." The only criticism was in regard to her slovenly appearance and untidy room. While at the Academy Julia's mother visited her irregularly and lavished clothing and other expensive gifts upon her. Julia spent the vacation periods in summer camps and seemed to enjoy these. Her mother committed suicide while Julia was at the Academy and the faculty and students were particularly kind and helpful. Julia was spending the day with her mother at her apartment in Boston on the day of the suicide. She has since expressed herself as being responsible for her mother's death as her mother had requested her to do something earlier in the morning and she refused. Our patient attended her mother's funeral only after persuasion but afterwards she seemed to put her mother out of her mind.

Shortly after her mother's death Julia was told to consider the paternal grandparent's home hers. This change was made following financial reversals by the maternal grandfather and the fact that he and his wife were in poor health. The paternal grandmother and aunt who took over her training and care considered Julia spoiled, selfish, and undisciplined. To correct these habits they set up rigid rules;- they chose her clothes, planned her vacations and held her responsible for any money given to her. The aunt said that Julia knew nothing that a girl her age and position should know. She knew nothing about housework and was not interested in learning. She was ignorant of even the simplest matters involved in preparation of meals. They felt that Julia was jealous of a cousin about her age but Julia never

showed or expressed jealousy; instead appeared to ignore the cousin. Julia has never complained of mistreatment by her relatives.

Up to this time this girl has been quiet, seclusive, and unable to make friends readily. She was ambitious to become a writer and thought to prepare herself for her field by constant reading. She never expressed an interest in boys or men. She was not religious but following her mother's death joined the Episcopal Church. As she grew older she smoked heavily, as much as three packages of cigarettes daily. Although this girl had never been thought of as an outstanding intellectual, about this time she developed an uncanny ability to outsmart people and to wheedle things from them.

The summer following her graduation from the Academy she spent with the paternal grandmother at her summer home in Maine. Her relatives found her uncooperative and unwilling to join in the family activities. Julia refused to dress in what they considered an appropriate manner and her shopping attire of shorts without hose displeased them. They were critical of her habit of sleeping late in the morning. They felt that she was unappreciative of what they were doing for her. During the latter part of the summer our patient became irritable, and nervous so that she was unable to sit still for five minutes. In preparing to continue her education her paternal relatives wanted her to attend a business college but Julia chose an academic one with high scholastic standards. When the fall term neared her grandmother and aunt selected her college clothes without consulting her.

At college Julia did not make friends. Her room-mate reported that she did not go to meals regularly but instead ate hamburgers, candy and soft drinks. She would leave college without permission and appear at her relative's home without warning and unable to give an adequate explanation of why she left college. Her relatives sent her back to college following each interruption of her studies but she did not adjust. She made two suicidal attempts; one by drowning in the bath-tub and another by attempting to jump

from a second story window. Following these attempts she was removed from college.

In her grandmother's home her behavior was difficult, she refused to get up, would not come to meals but ate sandwiches, candy and soft drinks. She refused to take a bath or wear a sanitary pad when menstruating. Her relatives engaged two nurses to care for her but because of continued suicidal threats she was admitted to a private mental hospital.

Julia was confused, depressed and cried a great deal for six weeks following admission.

She retained the suicidal tendencies and required constant supervision. Several times she was found secreting sharp instruments from the tool shop. The psychiatrist whom her relatives engaged to study her diagnosed her as a schizophrenic. She was admitted on November 29, 1940 and at her maternal grandparents' request she was released to them on March 26, 1941. Immediately they found it difficult to supervise Julia and shortly afterwards she was taken to another private mental hospital where she was diagnosed as having a psychopathic personality with a depression. She had four electro-shock treatments and after seven days was removed to a third private hospital on April 3, 1941 where the diagnosis was without psychosis; psychopathic personality. She was released on May 26, 1941. At that time Julia expressed the feelings that her relatives were "pushing her around" and refused to go with them. Her guardian arranged for her admission to the Boston Psychopathic Hospital where the diagnosis was manic depressive, depressed. It was believed by the staff there that Julia was in a convalescent state recovering from a hyperactive compensatory reaction to electric shock therapy following an acute depression. Her general activity was not too marked and it was felt that few features of her behavior showed any abnormality. She was hospitalized at the Boston Psychopathic Hospital from March 26 to June 2, 1941.

At that time her father who had just been released from the State Prison insisted on being given full responsibility for his daughter. Their guardians sent them both to a farm in N. H. but

after two days the proprietor refused to keep them because of Julia's behavior. Her father took a cottage for himself and his daughter in the same community. During this time Julia was neglectful of her appearance and immediately got in difficulties. She bought an automobile under an assumed name, pawned her jewelry, charged clothing that she did not need and could not pay for, and stole jewelry. She secured work as a clerk in a local store and embezzled funds. She was sarcastic and disagreeable to every one with whom she came in contact. Recognizing that he could not supervise or help her, patient's father notified her paternal grandmother who sent patient to a private mental hospital in another state. She remained there for three months showing manic tendencies throughout the time. She was such a behavior problem that although special nurses and attendants were engaged the hospital would not keep her and she was released on September 5, 1941 to her grandparents. The diagnosis at this hospital was manic depressive, depressed. Patient was transferred to the first private mental hospital where she seemed to take great delight in doing things that upset her family. She refused to cooperate in any program of treatment. The paternal grandmother had spent \$10,000.00 during the year and felt that since there was no improvement she could not continue to keep her granddaughter in private hospitals and she was committed to a State Hospital on October 19, 1941.

Julia did not appear concerned about the continued hospitalization. She made the best adjustment in this hospital where she was diagnosed as primary behavior disorder, simple adult maladjustment, and, was released on visit December 23, 1941 and discharged one year later. At the time of her release in 1941 her paternal grandmother refused to keep her and the maternal grandparents were themselves in a hospital. With the aid of a social worker from the Episcopal Church Julia was placed with an Episcopalian minister's family where she made a good adjustment for a year and earned her discharge from the State Hospital.

At the end of the year she became overactive and began to steal so the minister requested her family to remove her. The same conditions obtained as at the time of her placement so the social worker was again asked to assume responsibil-

ity for Julia's placement. She was placed in the Y.W.C.A. and at different clubs in Boston where she remained from one day to a week. In each case she was asked to move. Within a short time Julia disappeared and when next heard from she was being held by the Court in an adjoining state.

When Julia left the state she secured work under an assumed name in one of the private mental hospitals in which she had been a patient. She was recognized the second day and given fare to return to her home. Instead, she secured work in a local department store. While employed there she charged merchandise to the account of a girl she knew slightly. This was discovered and she was brought into Court and her relatives notified. They expressed themselves as being "exasperated with her escapades." Recognizing her behavior was of intellectual disorganization they asked the Court to commit her to this hospital which she entered on February 4, 1946.

This child of Very Superior intelligence was "too old for her age." The environment and family relationships which her immature, irresponsible and pre-psychotic parents brought to her required many adjustments. English and Person believe "that when a child has been separated from one or both parents there will always remain a psychic scar which will affect his relationships, happiness, and success to a greater or less extent." If Julia could have had a permanent home with one set of grandparents she probably would have had a better chance to develop with less difficulty. The grandparents were exactly opposite in their own personality make-up, attitude towards their grand-daughter, and in their values. The maternal grandparents were affectionate, casual, comfortable in every sense of the word and

over-indulgent. The paternal grandparents were rigid, aggressive and puritannical. Julia was shifted between them at irregular intervals without preparation for the change or affectionate guidance.

Carroll believes "The brighter the child the more problems (she) has. As a child and as an adult (she) is aware of complexities which never impinge upon the consciousness of the person of average ability." This girl of unusual potential ability could not escape the feeling of rejection by her parents, and of hostility between the families. From the history and interview with relatives one gets the impression that no one thought of what this confusion, lack of a normal family relationship would mean to Julia. She appears to have chosen her way of meeting the many difficulties by a superficial docility and withdrawal.

TABLE XV
A DIAGRAMMATIC HISTORY OF CASE STUDY 1

	25	
	24	
Lack of permanent	23	
and normal family	22	
relationship	21	- Maternal grandparents suffered re-
	20	verses and ill health
Over weight	19	Mal-adjustment at college
	18	
Father's alcohol-	17	- Placed with paternal grandmother
ism and instabil-	16	
ity	15	Mother committed suicide
	14	
	13	
Rejection by	12	
mother	11	
	10	- A happy year with mother in New York
	9	
	8	
	7	
	6	Over-indulged, spoiled by grand-
	5	parents
	4	Mother remarried and left patient
	3	with grandparents
	2	- Mother attempted suicide
	1	- Parents were divorced
	0	- Birth; 10½ pounds; born to immature,
		unstable, emotional parents

Case Study 2

Agnes has a diagnosis of schizophrenia, paranoid type. She has an I.Q. of 170 which classifies her as Very Superior in intelligence with a 98 percentile rating. On the Shipley-Hartford Retreat Scale she earned a conceptual quotient of 102 which is normal and does not suggest any deterioration. On the Bell Adjustment Inventory she rated Very Aggressive Socially. For the Home, Health, Emotional and Occupational Adjustment areas the ratings were

* Chart after Strecker, Fundamentals of Psychiatry, p. 26.

Excellent. The Total Adjustment on this personality inventory is also Excellent, which is surprising for an individual recently admitted. However, patient is keen intellectually and may have been test-wise with an ability to cover up. She is quite a verbalist with attention to details often not important; gracious and amiable yet rather firm and tenacious in some of her ideas.

The family history of this patient is non-contributory. The father, age 78, is living and well. He is a retired civil service employee who held the same position of responsibility for over thirty years. He is respected by the citizens and is considered to have an admirable character. Her mother, age 84, is said to have always had a rigid and dominating personality.

Agnes was born December 29, 1895 in Massachusetts. Her birth and early development were normal. At the age of four years her brother was born and her subsequent conflicts appear to arise from the feelings of jealousy which his birth and preference by their mother aroused. She had whooping cough prior to entering school, but no other disease, and she has never had a serious illness, operation nor injury. Agnes was graduated from the High School in 1914, attended an Eastern college and secured a B.S. in 1918. She taught in her home town for two years and then studied at a Western University where she obtained her master's degree. She has continued to study and was a recognized authority in her special field. For four years following the graduate work she held three different positions and then she returned to the Western city where she attended the University and took the position of associate professor. During this time she had an apartment and lived alone preparing her own meals.

During the summer session of 1928-1938 she taught at Johns Hopkins, and at Columbia University 1938-1943. She was given a leave of absence in 1935 to teach and organize a department in her field at a University on the West coast.

Symptoms of her illness were observed as far back as 1930. At that time this patient began to express many persecutory delusions and paranoid

ideas. These became more and more systematized during the years. Among the early ones was a belief that clerks in the shops deliberately gave her the wrong change. Later, these involved fellow instructors and University staff members who she felt were plotting against her. She felt that her friends at the University made fun of her and were watching her at all times when she traveled.

A few years after moving to the city in which she taught she became interested in a prominent minister of the city. He paid her some attention but our patient's father who knew of her interest and who met him thought he was not the marrying type. Agnes attended services and believed that different parts of his sermons carried special messages to her. If she chanced to see him at social gatherings she read into his presence certain inferences regarding herself. These delusions became increasingly more intense and played a more important part in her relationships with members of the staff as years passed.

In the spring of 1944 Agnes was working long hours, traveling a great deal for lectures and was not sleeping well. She had reduced her food intake believing that many foods were poisonous to her. For years she had refused to eat foods containing eggs, wheat, yeast, baking powder; and she refused milk in all forms, claiming that it gave her diarrhea. She is said to have developed intestinal symptoms at intervals accompanied by a marked urticaria. An allergy specialist following tests advised her that she showed no allergy to these foods and suggested that she return to a normal diet. She refused to do so and continued to lose weight. At the time of her admission she was described as frail and undernourished. Despite the physician's recommendation that she rest, Agnes was determined to complete the year's work and to keep her lecture engagements.

Following the end of the University term she returned to her parents' home in June 1944. She accused her father and friends of plotting against her. She said that fellow instructors were responsible for the delay in arrival of her baggage,

believing that they did this in order to confuse her. She spoke of the fact that her ticket to Boston had New York printed on it also; and she believed again that her friends had this done in order to test her ability to travel. A part of the delusion centered around the reports that her friends were giving her gentleman friend which prevented his asking her to marry him. She was actively hallucinated in the visual and auditory fields. Agnes thought that she could see her friend wherever he was speaking, or on his visits to the theater in another city, and claimed to have heard his voice. She was suspicious of her father and accused him of preventing her from seeing her friend when he came to visit her though actually he did not visit her.

Agnes was admitted by her parents on June 24, 1944 following an episode in which she waved a revolver and threatened her mother. At the time of admission this patient was excited, violent and assaultive. She was manneristic with many facial grimaces, winking of the eyes and smiling. She had no insight or judgment; and, was potentially suicidal. When asked her name and age, she said that she had forgot; was sarcastic and refused to give any information about herself. She was contradictory, spoke of talking with her father earlier in the morning and a few minutes later saying she had not seen him for 18 months. Her speech was coherent and there was no marked flight of ideas, though she announced that she was head of the police department and could do as she pleased. She laughed and joked with the officers who brought her and ignored the physician. She explained her admission to this hospital as a part of a plot of her father's and showed many paranoid ideas connected with him. She showed marked splitting and dissociation and was in a state of upheaval.

Following a period of observation she was diagnosed dementia praecox, paranoid type and regularly committed. She was quiet, but rather tense, refused to eat; and was restless. She remained aloof, was slightly depressed, suspicious and hallucinated for some time. Following shock treatments given a month after admission she showed marked improvement. She was given parole but this was later taken away. Agnes was allowed out on visit at Thanksgiving and Christmas. Her parents asked that she be allowed

out on indefinite visit and this was approved. They returned her after a few months and she remained in the hospital for the following thirteen months. She has been on visit against advice since July 1946.

In this case we believe that the contributing factors arise in the family relationships where we find that the parents failed to recognize that Agnes felt rejected by her mother who favored the patient's younger brother. Agnes was jealous of him and her rivalry is evidenced in her determination to excel and thereby win recognition for herself. According to Dr. Thom "Jealousy between the ages of one and five is a normal reaction common to most children, yet often through accident or deliberate fostering, this emotion may become so exaggerated and dominant in the personality, as to make it inevitable that serious difficulty in social adaptability should follow." We recognize that the reaction is normal and will persist, taking many forms throughout life unless it is recognized and the child made to feel equally secure in her parents' affections. In early childhood Agnes found that she could win and maintain the approval of her parents, particularly the mother's, which she needed the most, by being the conformist which her brother was not. She determined to be a model child. She, not her brother, would be the outstanding success. During this early period in which Agnes was doing many things against her desire, childhood tensions were created in her

struggle to win the mother's favor. Agnes became aware during this time of the unfairness within the family constellation. Her brother was an ever present threat to her status, and with him she quarreled bitterly. The mother was never able to recognize why her children were not loving and congenial. This feeling of competition persisted and expressed itself at different levels in different ways. At the high school age she recognized that her brother was more adequate socially than she and began to withdraw from social and group activities. She could not make herself accepted by either boys or girls. At the college level her jealousy increased as her brother had greater freedom than her parents permitted her, and was able to let the bars of family standards down a bit without securing the parents' condemnation. And even though she wanted to she could not for she had to be the model child.

This patient did not identify with her mother, and because of the conflict regarding her femininity she was not able to identify with other mother figures as teachers, friends, etc. We can only speculate regarding the family relationships but recognize that the passivity of her father may have been a defense against his wife's aggressiveness. It was a method of self-preservation. This same trait carried over into his community life made him popular. He held a political position without opposition for over 30 years

and remains a well-liked and respected member of the community. We can believe that Agnes's social adjustment and professional activity were disturbed by her fantasies regarding her friend. He played a larger part in the life than is reported. Helene Deutsch believes that in such cases analysis may help a woman transform her passive identification with her mother into an advanced active one. The drive to excel and her intellectualizing, according to Helene Deutsch, suggests that "intellect plays the part of a defense mechanism in every condition of life; when an emotion is expected an idea appears. Many intellectual women are actually only fugitives with impoverished emotions." We see here a common condition among women at the climacteric period; they display a pseudo-hypomanic activity. Further characteristics of this patient are described by Helene Deutsch:

Many women in an attempt to strengthen their self confidence, which is disturbed by the narcissistic mortification of the climacterium, avoid social life because it reminds them of the sad reality, and withdraw into a "splendid isolation."

Women's relation to her own sex often undergoes a change in the climacterium. Friendships preciously loyal and harmless begin to be troubled; well sublimated homosexuality is subjected to the same tests as sometimes in puberty; the sublimation is no longer sufficient, new demands are made, jealousy appears. . . . Paranoid ideas in the climacterium usually result from an intensification of homosexuality previously latent. . . . Sometimes they inaugurate a chronic psychotic process.¹

¹ Helene Deutsch, Psychology of Women, Volume II, p. 465.

This patient's academic and professional success was unquestionable. The work was satisfying but not enough to offset her sense of failure in one of the basic areas of her life.

TABLE XVI

A DIAGRAMMATIC HISTORY OF CASE STUDY 2

	51-52	
	49-50	Development of psychosis
	47-48	
	45-46)	
	43-44)	Climacterium
	41-42)	
	39-40	
	37-38	
	35-36	Unreciprocated interest in
	33-34	minister
	31-32	Food allergies; loss of weight
	29-30	
	27-28	
	25-26	
	23-24	
Sibling rivalry	21-22	
	19-20	
Lack of femininity and rejection of feminine role	17-18	
	15-16	Unsuccessful socialization
	13-14	
	11-12	Development of neurotic traits
	9-10	
	7- 8	Sibling rivalry
	5- 6	
	3- 4	Birth of brother
	1- 2	
	0-	Birth

Case Study 3

Louise has been hospitalized for five consecutive years with brief periods of placement which were terminated after a few weeks. The diagnosis is psychoneurosis, mixed type. When given

* Chart after Strecker, Fundamentals of Psychiatry,
p. 26.

the Wechlser-Bellevue Ability Test she showed uncertainty and belittled herself but responded well to encouragement. Her I.Q. of 131 classifies her as having Very Superior Intelligence. On the Healy Picture Completion Test, Form II, which is a test of judgment Louise earned a mental age of 18 years and 2 months which is also an excellent score. She had a great deal of difficulty solving simple problems.

The family history appears contributory. Paternal and maternal grandparents died in mental hospitals; the maternal grandmother was suicidal. Several maternal aunts are described as "queer." Patient's father is living and in good health. He is proprietor of his own small business in which he is successful. He was an only child and said to have been spoiled and to be very disagreeable in the home. The patient's mother is living and has a cardiac condition. She had infantile paralysis as a young girl and has a residual limp. She is highly emotional, unusually stubborn and dependent upon her family. It is said that she had several "nervous breakdowns" though none of these required hospitalization and there has been no medical diagnosis. She was confined to her bed in 1932. Nature of this illness was never stated. Louise has a sister, ten years older, who is said to be neurotic. She has a rigid personality and the sibling relationship has never been an affectionate one.

Louise is the younger of two daughters. She was born December 15, 1912 at 8½ months and weighing four pounds. She cried continuously for the first six months and was rocked continuously by her mother. Having been indulged by her mother throughout infancy and early childhood her mother was unable to train her or secure obedience to simple requests. At four years our patient's father took over in an effort to train and discipline her. He was poorly equipped for his task and soon lost patience with her. Louise had learned to obtain what she wanted by crying and at times she made the situation in the home so difficult that her parents threatened to whip her. Louise was frightened by these threats, though corporal punishment is denied by relatives. This girl had mild cases of chicken-pox and measles prior to entering school. At four

years she fell down a flight of stairs but the examination at the time and subsequently did not suggest any permanent injury.

Louise entered school at six years and made normal progress. Her education was interrupted at the age of 13 by a "nervous breakdown." All symptoms of her illness appear to date back to the time when this patient was entering adolescence. Numerous important events took place at that time. Her mother discovered her reading a book "about babies" and then proceeded to teach her daughter about this subject. This abrupt presentation was a great shock to her. She was unprepared for her first menstruation and this frightened her. We recognize that it is important at puberty, the onset of normal menstrual function, that the girl should be given a biological understanding of herself as a woman. Menstruation has a great significance in a young girl's psychology. During this period of confusion Louise began to masturbate and continued the practice until the time of her hospitalization. Her mother's own attitude towards sex was not normal. Since attitudes are subtly and effectively transferred from one member of the family to another, it is to be wondered how much of the mother's abhorrence of sexual relations was passed over to patient. Louise was out of school for two years following this first nervous breakdown. Following her return to school she seemed improved and was on the Honor Roll throughout High School.

Up to this time Louise had been a timid, hypersensitive and fearful person. The familial traits and developmental experiences suggest a predisposition for personal abnormality. Louise expressed many fears, particularly that mental illness was "catching." We find in her history an over-attachment to the mother. Dr. Helene Deutsch writes, "attachment to the mother represents a greater danger than attachment to the father. The mother is a great obstacle to the

girl's desire to grow up and we know that the condition, "psychic infantilism" found in many adult women represents the outcome of an unresolved attachment to the mother during pre-puberty." A girl with a weak ego can not break the identification. English and Person believe that the adolescent should be a fairly well integrated person by the time she enters her teens. This is usually the last period of dependence and the last period when environmental forces can help the individual move towards independence. Throughout this patient's life there has been a "failure to balance and direct the natural functions." Where such condition exists the girl is predisposed to personality difficulty and even to mental breakdown.

When Louise entered an Eastern University she was an excellent student and on the Dean's list during her freshman and sophomore years. In 1932 when Louise was a sophomore her mother was confined to her bed. It was said that Louise was responsible for all the house work and nursing care in addition to her University studies. She left the University during her Junior year because of another "nervous breakdown." Following the interruption of her education she increased the close relationship with her mother. For several years prior to her admission to this hospital Louise and her mother occupied the same bedroom while her father had a separate room. The ten years following Louise was a chronic invalid. She had a great number of doctors, eighteen, of all varieties. Since 1925 Louise has passed from one doctor to another. She was frequently told to "snap out of it" or that "it was all in her mind and that she imagined her troubles." She was in analysis for two years and grew progressively worse. This condition lasting over ten years caused greater and continued withdrawal from normal life; a continuous increase in symptoms to a degree which made

patient express suicidal ideas. She began to feel that her mind was affected; her behavior became so difficult and Louise so frightened it seemed best to admit her to a psychopathic hospital. Because of the anxiety, depression and expression of suicidal ideas patient was admitted to a private mental hospital. During the month of hospitalization Louise was anxious, depressed, wept a great deal and expressed suicidal ideas. She also had an exaggerated reaction to noises. When it appeared to her parents that she would require a long period of hospitalization she was transferred to this State Hospital.

At the time of admission she expressed many persecutory beliefs and had a great many ideas of reference. She said, "I know I am dirty, I heard the nurses say I was dirty, I have no folks now, I am doomed, you can't fool me. You all hate me and you're going to make me pay for it. I don't blame you." She was emotionally depressed and cried frequently, appeared sleepy and without spontaneity; there was retardation without blocking, and a prominent fear of "insanity." The physical examination was essentially negative. Her general health was poor because of constant distress caused by frequent urination. The physical cause of this symptom is not definitely known. It had been diagnosed prior to admission as chronic urethritis and also "merely a bad habit." In 1934 she had an operation for a cystic ovary. A neurological examination was entirely negative. An electro-encephalogram report states that the record is atypical of epilepsy but is more like that seen in psychomotor disorder than in any other pathological condition. The condition was described by the specialist as "baffling." The brain waves are far from normal but the abnormality is not of any specific type with which we are familiar. Louise was given hydrotherapy, psychotherapy, industrial and occupational therapy. After a series of shock treatment she remained unimproved. Although this diagnosis is not a psychosis, her status for the past twenty-one years has been one of such personality disorganization that she can not function normally; and, at this time is unable to remain outside the hospital for any length of time. Prognosis is guarded.

TABLE XVII

A DIAGRAMMATIC HISTORY OF CASE STUDY 3

	29	Disabling psychoneurosis appeared
	28	
	27	Analysis - no improvement
	26	
	25	Forced to discontinue her education
	24	
Parental friction;	23	
hereditary traits	22	
	21	
	20	
	19	Limited social life
	18	
Rejection by	17	
father	16	Nervous breakdown lasting 2 years
	15	
	14	Nervous breakdown
	13	Upset by first menstrual period; poor
	12	instruction re: birth and pregnancy
	11	
	10	
	9	
	8	
	7	
	6	
	5	
	4	Fear of father because of discipline
	3	
	2	
	1	Abnormal development and treatment
	0	Birth; 8½ months weight 4 pounds

In each of these histories we find that each patient had an underlying feeling of insecurity with her parents. In the attempt to gain security, and overcome feelings of inadequacy and rejection, each woman developed her own peculiar kind of symptomatic behavior. We observed in the

* Chart after Strecker, Fundamentals of Psychiatry, p. 26.

three cases reported, and this held true in the histories of all the women, that intellectual capacities represent but one aspect of mental life. There are other psychological traits, including the dynamic and emotional phases of personality, which are of crucial importance in the appraisal of a human being.

CHAPTER VI

CONCLUSIONS

These questions may be put following this study undertaken to investigate the developmental and environmental history of one hundred psychotic women of superior intelligence who have been patients in the Metropolitan State Hospital. (1) What are the important findings which may be described as hereditary? (2) In what ways does the history of these women indicate that the environmental stresses can be considered as contributory to the development of the psychosis? (3) What other factors entered into the life of the women that might be described as contributing to the mental illness? (4) Does the study lead to any suggestions which may prevent mental illness?

(1) In discussing the etiology of mental illness heredity is often mentioned first since it is a basic consideration. We do not know how much of intelligence is included in the gene but the studies of Galton and Terman suggest that heredity marks the limits of intellectual powers. Galton reported from his study that the capacity of the parents has far more influence upon the intellectual capacity of the child than does that of ancestors further removed. Terman found that mentally superior children are much more likely to possess mentally superior relatives than average children. In the family history of the women

of this study we do not find any mental defectives. We conclude, therefore, that family is definitely of importance in the creation of high mentality.

Fifty-nine of the women of this study are known to have relatives who were psychotic. The diagnoses are not definitive for the majority of relatives. Since there is a limited number of psychoses said to be inherited through the germ plasm the study suggests that heredity was not an important factor in the development of the psychosis. The study of the family history as far back as the grandparents was worthwhile as it furnished information regarding the family stability, but the study does not indicate that the mental disorders are hereditary in the ordinary sense of the word. Rather these mental disorders of parents and grandparents may provide a constitutional predisposition, or it may be that the women of this study grew up in an environment similar to that of the relatives who became mentally ill. The current opinion regarding the part heredity plays in creating personality difficulties is succinctly expressed by Dr. ives Hendricks as follows:

Much that determines individuality, such as characteriological trends, and whether a neurosis will be predominately an obsessional or an hysterical defense against anxiety, are determined presumably by hereditary factors. Yet, the discoveries of psycho-analysis should be sufficient warning not to accept too complacently inborn "constitution" as the explanation of every human peculiarity. Fifty years ago hysterical people were believed to be "just made that way." In short, the more

we learn, the less we need ascribe to heredity. Much that was previously thought to be family resemblance and predisposition, transmitted by the germ plasm, is now known to be the responses of infants to the emotions of their parents, which eventually become through habit, and identification, character and behavior patterns.¹

We know that a healthy personality is more than superior intelligence but we can not show in this study that mental illness per se was inherited. Educators and psychologists agree that it is almost impossible to distinguish what is inherited from the product of training.

(2) The study of the environmental factors was made to learn the kind of home from which each woman came, what type of parents and siblings she had, what social and economic elements of the environment may have influenced her as a child. Deprivation, often considered a potent force in the development of behavior aberrations, was present for only five of the women. The general environmental factors appear to be negligible as contributing factors, but the emotional conflicts that had a direct bearing and contributed childhood traumas arose within personal relationships of the woman's family and environment. The pressures engendered by the social milieu of the women of this study are described by Strecker and Ebaugh as follows:

All of us are subject to general environmental hazards. These include the considerable emotional penalty that must be paid for the kind of civiliza-

¹ Ives Hendricks, Facts and Theories of Psychoanalysis, pp. 189-190.

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All of us are subject to general environmental pressures. These include the considerable emotional penalty that must be paid for the kind of civilization

tion in which we live,—mechanized, highly industrialized, standardized, patterned, monotonous but still brutally competitive and over luxurious. . . . These handicaps of civilization serve to act as deterrents to the satisfaction of normal human instincts and desires, marriage, children, home-building, etc.

Although all human beings, except primitive savages, must accept these conditions and make the best of them, still individual resistance is very variable. It may be relatively insufficiently innately, or at some particular cross-section in life the resistance may be dangerously diminished due to a series of external drains. Such events may widen the flaw in the personality so that a mental break results— a penalty exacted by our civilization.

Since they should be to some extent avoidable, the personal predisposing environmental factors are more important than the general. They are embraced in the failure to provide children (all of whom are deeply impressionable emotionally) with even a minimum of satisfactory emotional mental hygiene. The child who feels emotionally insecure is potentially the victim of nervous and mental disease in adult life. A few of the childhood situations which are fraught with predisposing danger are these, failure to help children emancipate themselves from parental authority and decision however "loving" it may be; brutal or impersonal and non-explanatory discipline; spoiling, lack of sex information which favors maladjustment to the sexual function later in life and perpetuates sex fantasy; constant friction between parents; and many other liabilities of omission and commission on the part of parents and others entrusted with the care of children. So many of these unhygienic personal environmental factors are so directly reflected in the psychoses and psychoneuroses of adult life; that we dare not discount the predisposing effect of personal environmental factors, particularly in childhood.²

The findings of this study reveal that those factors which may be described as contributory, those which aroused

² Edward Strecker and Ebaugh, Clinical Psychiatry, p. 14.

conflicts that germinated and grew into full blown psychoses had their origin in the interpersonal relationships as mentioned by these psychiatrists. Because of these disturbances these one hundred women of superior intelligence lacked the emotional stability required to retain their places of responsibility. All of these mentally ill women were once babies, babies who were denied the right to develop to the fullest "the natural resource of life energy within them." The case histories of these women differ in detail but strike a certain mean in which early disturbances of the personal relations was a directly contributing factor in the development of the mental illness. Psychiatrists and psychiatric social workers believe with Dr. Ribble that:

Human personality is a continuous development and healthy emotions, as well as a free creative intelligence, are rooted in the early infant experiences. Doctors who concern themselves with mental health constantly find that unsocial behavior, as well as the more extensive personality disorganization which we know as mental illness, lies in maladjustment which begins to be established in earliest infancy.³

Life for the girl begins in her parents' home. It is there that patterns of behavior within her culture are laid down, tried out and accepted as her way of life. It is in the home that she learns how to relate to others and what she may expect from these established relationships. It is in

3 Margaret Ribble, *The Rights of Infants*, p. 101

the home that her attitudes are determined by what she sees and what she hears and the emotions aroused by these experiences. It is evident that the women of this study acquired their inner feelings about life and themselves very early; and very early learned techniques for dealing with situations in their own peculiar and abnormal way. These techniques were manifested in different ways during childhood and adolescence, and stand out in their adult experiences. Many of these women as children met difficulties by withdrawing from them, by employing a persistent fantasy life, and by showing strong attachment to one or both parents.

(3) There is enough of a suggestion in the histories of the younger women, those who grew up in the twentieth century, that in addition to certain familial traits and experiential influences that certain anxieties rose from the conflicts which centers around the status of women today. In our American culture certain parental-economic objectives are assigned to men at birth. They are expected to assume a certain role in respect to women and to acquire some occupational skill that will enable them to support their families when they have married. There is no conflict between man's life emphasis and the cultural pattern for these coincide. This coincidence does not obtain for women. Women face a dual responsibility and a set of conflicting interests arise out of this duality, which follows her from

childhood through adolescence into maturity. The cultural expectation is that the girl will marry, have a home and a family. All her conditioning and part of her educational experiences follow this line of interest. With the increased standard of living men must of necessity delay marriage, which means for the girl an interim period for which there is no determinate goal. Many girls prepare for this by vocational training but with the expectation that marriage, her ultimate goal, will interrupt her vocation. Since employment is expected to last a short while she lacks the drive and fails to secure the satisfaction from the chosen vocation. If, on the other hand, the employment role becomes permanent against her wishes, she must resolve her frustrations in some acceptable direction.

Little has been done to understand women's basic needs and problems because of the changing pattern in our American culture. In the dual role attempted by women of superior intelligence there are many prejudices and difficulties which render sterile the satisfaction in this role she attempts. The extent to which she was accepted, rejected, dominated or over protected, the status which she failed to attain and the sense of importance that she was unable to carry with her were basic in the development of conflicts for many of these women of this study. The home should provide the attitude and assist in providing the opportunity

childhood through adolescence into maturity. The cultural expectation is that the girl will marry, have a home and a family. All her conditioning and part of her educational experiences follow this line of interest. With the increased standard of living men must of necessity delay marriage, which means for the girl an interim period for which there is no determinate goal. Many girls prepare for this by vocational training but with the expectation that marriage, her ultimate goal, will interrupt her vocation. Since employment is expected to last a short while she lacks the drive and faith to secure the satisfaction from the chosen vocation. If, on the other hand, the employment role becomes permanent against her wishes, she must resolve her frustrations in some acceptable direction.

Little has been done to understand women's basic needs and problems because of the changing pattern in our American culture. In the dual role attempted by women of superior intelligence there are many prejudices and difficulties which render sterile the satisfaction in this role she attempts. The extent to which she was accepted, rejected, dominated or over protected, the status which she failed to attain and the sense of importance that she was unable to carry with her were basic in the development of conflicts for many of these women of this study. The home should provide the attitude and assist in providing the opportunity

that enables a woman to meet this difficult situation with emotional stability. These women of superior intelligence and others like them will meet domination, rejection, loss of status on the job, at school, and in social situations, and the kind of adjustment and adaptation that they can make to these experiences will depend on the feelings of security, love and expectation of justice that is founded in the home and the family relationships.

(4) What can be done to prevent the increase of psychic-imbalance that results in mental illness? Education is the force that can constructively bring about an understanding of the cause of mental illness and methods of prevention and treatment. The following suggestions are practiced now but there is need for inclusive and intensive work in these fields. First, in parent education for the time to prevent the development of personality difficulties in earliest childhood. Parents have the first, the most intensive, and the most persistent job of training the child, but they need help. Unless they are given such help there can be little hope for anything but a repetition in each family of the pattern laid down in their parents' home. As one educator observed, "What parents do to their children and what they think they do are often two different things."

It was interesting to see the extent to which the women of this study repeated with their own children the patterns

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(4) What can be done to prevent the increase of psychical imbalance that results in mental illness? Education is the force that can constructively bring about an understanding of the cause of mental illness and methods of prevention and treatment. The following suggestions are practiced now but there is need for inclusive and intensive work in these fields. First, in parent education for the time to prevent the development of personality difficulties in earliest childhood. Parents have the first, the most intensive, and the most persistent job of training the child, but they need help. Unless they are given such help there can be little hope for anything but a repetition in each family of the pattern laid down in their parents' home. As one educator observed, "What parents do to their children and what they think they do are often two different things."

It was interesting to see the extent to which the women of this study repeated with their own children the patterns

of parent-child relationship familiar to them in their own home. It is startling to note that the problems each woman experienced with her own children were an almost exact duplication of the ones she reported in relation to her own parents; namely, parental over-protection and domination, rejection, sibling rivalry, lack of knowledge of child care, training and normal behavior. Nothing is known of how seriously these women have affected the attitudes and nature of their own children. But from the experience of the women of this study who came from homes in which there was a psychotic member or unstable parents we can expect the pattern to be repeated in some respects unless corrective measures are provided. Prevention must be geared to those who associate with the child most intimately. This means that faulty notions of parents must be corrected. Kanner advises:

Most of the recommendations would be almost futile and at times even create additional problems if we fail to establish parental cooperation. We have seen how parental over-protection, over-indulgence, carelessness, rejection, etc. are highly important in the development of behavior disorders. The need of a correction of any unhealthy parent-child relations is therefore imperative. Such a change can take place only if the necessity and practical application has been demonstrated to the parents, intelligibly, convincingly, and concretely. ⁴

The second field is in education for marriage. Many problems of husband-wife relations arise from personality factors which have their origin in the early conditioning of

⁴ Leo Kanner, Child Psychiatry, p. 126.

of parent-child relationship similar to those in their own home. It is essential to note that the problems each woman experienced with her own children were an almost exact duplication of the ones she reported in relation to her own parents; namely, parental over-protection and domination, rejection, sibling rivalry, lack of knowledge of child care, training and normal behavior. Naturally in view of the fact that these women have affected the attitudes and behavior of their own children. But from the experience of the women of this study who came from homes in which there was a psychotic mother or unstable parents we can expect the pattern to be repeated in some respects unless corrective measures are provided. Prevention must be geared to those who associate with the child most intimately. This means that family relations of parents must be corrected. Kanner advises:

Most of the recommendations would be almost futile and at times even create additional problems if we fail to establish parental cooperation. We have seen how parental over-protection, over-indulgence, over-possessiveness, rejection, etc. are all important in the development of behavior disorders. The need of a correction of any underlying parent-child relationship is therefore imperative. Such a change can take place only if the necessary and practical application has been demonstrated to the parents, intelligently, consistently, and cooperatively. *

The second field is in education for marriage. Many problems of husband-wife relations arise from personality factors which have their origin in the early conditioning of

the girl in the family. These may prevent the girl when reaching adulthood from developing heterosexual relationship which culminates in marriage. These early conflicts may prevent the realization of the physical and emotional demands of marriage, or pregnancy, of child-bearing, and motherhood.

The third broad program would consist of adult education which will furnish basic information regarding the origin of personality abnormalities. There is still a wide gulf between what is known by the experts and what is known by the great mass of people. The fourth area for practical education is in the training of personnel for the expansion of the physical and mental health facilities. Specialized care and attention is required to correct the physical, emotional and behavior difficulties of children and of adults.

In summary the findings are general but emphasize the fact that has been repeated throughout the thesis that mental illness is not an isolated problem but one of a more complex nature depending upon the personal reactions to individual problems. As Dr. William A. White writes:

In a certain sense, a large number, if not all of the psychoses can be considered life reactions. That is, a defect or adjustment only develops upon the basis of some weak point in the personality make-up and that weak point can be traced to its developmental beginnings in early life. The foundation of a possible psychosis is therefore laid in every life to the extent that there is imbedded in the personality at some point a capacity for adjustment that is any way short of practical perfection. It only needs the play of appropriate stresses to seek

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out this defect and discover it in the symptoms. ⁵

In other words, the average mind, under the influence of stress does not become deranged unless from the operation of traumatism, toxemia, or extreme degrees of exhaustion and not even then with anything like the facility of the mind predisposed to disease by bad heredity or unconscious complexes. ⁶ . . . It must not be forgotten too, that the occurrence of one attack of mental disorder predisposes to subsequent attacks. ⁷

Invariably in the case histories there were environmental pressures but not of sufficient intensity to cause the psychopathology. During the developmental period, after the individual has been exposed to one or more psychic infections there is a period of incubation. In this period there are potentialities for both normal and abnormal behavior. That is where therapeutic work may accomplish something. As Dr. Lowrey writes, "The individual organism whether diseased, psychotic or healthy, is only one part of the equation which results in social adaptation or social maladjustment. It is impractical and unwise to base the psychosis in any one factor exclusively." The general findings briefly posited suggest that it is the failure to give balanced direction to the natural functions of girls such as these women were in their early life that predisposes to personality difficulties and even to mental illness.

5 William A. White, Outline of Psychiatry, p. 40.

6 Ibid., p. 41.

7 Ibid., p. 45.

APPENDIX A

Case Schedule

Name	Birthdate
Birth: Normal Difficult	Birthplace
Family History: Grandparents	Unknown
Parental siblings	
<u>Problems of parents</u>	<u>Parent-child relationship</u>
1. Friction	1. Over-indulged and over-protected
2. Alcoholism	2. Neglected and abused
3. Physical and mental health	3. Rejected
4. Separation and divorce	4. Satisfactory
<u>Sibling Relationships</u>	<u>Childhood Problems</u>
1. Normal	1. Incidence of disease
2. Abnormal	2. Neurotic traits
3. Unknown	3. Traumatic events
<u>Economic Status of the Family</u>	<u>Vocation</u>
1. Income	1. Vocation of Parents
2. Type of home	2. Vocation of Patient
3. Type of neighborhood	3. Vocation of Husband
<u>Social Status: Single, married, widowed, divorced, separated</u>	
<u>Courtship and Marital Adjustment</u>	
Personality as a child	Age at time of admission
Personality as an adult	Hospital age
Onset of illness	Number of admissions
Present Status	

APPENDIX A

Case Schedule

Name	Birth: Normal	Difficult	Birthplace	Birthdate
Family History: Grandparents				
Parental Alliance				
<u>Problems of parents</u>				Parent-child relation-
1. Friction				ship
2. Alcoholism				1. Over-indulged and over-protected
3. Physical and mental health				2. Neglected and abused
4. Separation and divorce				3. Rejected
<u>Sibling Relationships</u>				4. Satisfactory
1. Normal				<u>Childhood Problems</u>
2. Abnormal				1. Incidence of disease
3. Unknown				2. Neurotic traits
<u>Economic Status of the Family</u>				3. Traumatic events
1. Income				<u>Vocation</u>
2. Type of home				1. Vocation of Parents
3. Type of neighborhood				2. Vocation of Patient
<u>Social Status: Single, married, widowed, divorced, separated</u>				3. Vocation of Husband
<u>Cooperation and Marital Adjustment</u>				
Personality as a child				Age at time of admission
Personality as an adult				Hospital age
Onset of illness				Number of admissions
Present Status				

APPENDIX B

BIBLIOGRAPHY

- Allen, Fred H., Psychotherapy with Children, W. W. Norton Co., New York, 1942
- Allport, Gordon W., "Personality," A Psychological Interpretation, Henry Holt and Company, New York, 1937
- Bradley, Charles, Schizophrenia in Childhood, The Macmillan Co., New York, 1941
- Cantor, Nathaniel, "What is a Normal Mind?," American Journal of Psychiatry, November 1941, p. 51.
- Carroll, Herbert, Genius in the Making, The McGraw-Hill Book Co., New York, 1940
- Deutsch, Helene, Psychology of Women, Girlhood, Vol. I, Grune and Stratton, New York, 1945
- _____, Psychology of Women, Motherhood, Vol. II, Grune and Stratton, New York, 1945
- English, O. S., and G. H. J. Pearson, Emotional Problems of Living, W. W. Norton Co., New York, 1945
- Foster, Robert, and Pauline Wilson, Women after College, Columbia University Press, 1942
- Hendricks, Ives, Facts and Theories of Psycho-analysis, Alfred A. Knopf, New York, 1946
- Hollingsworth, Leta, Gifted Childred, Their Nature and Nurture, The Macmillan Co., New York, 1926
- Kanner, Leo, Child Psychiatry, Charles C. Thomas, Baltimore, Md., 1935
- _____, "Early Behavior Problems as Signposts to Later Maladjustment," The American Journal of Psychiatry, Vol. 97, No. 6; 1261-1271
- Levy, David, Maternal Overprotection, Columbia University Press, New York, 1943
- _____, Sibling Rivalry, Oxford University Press
- Lorand, Sandor, Editor, Psycho-analysis Today; Its Scope and Function, Covici-Friede Publishers, New York, 1933

APPENDIX B

BIBLIOGRAPHY

- Allen, Fred H., Psychiatry with Children, W. W. Norton Co., New York, 1942.
- Allport, Gordon W., "Personality," A Psychological Interpretation, Henry Holt and Company, New York, 1937.
- Bradley, Charles, Delinquents in Childhood, The Macmillan Co., New York, 1941.
- Canter, Nathaniel, "What is a Woman's Mind?" American Journal of Psychiatry, November 1941, p. 51.
- Carroll, Herbert, Genius in the Making, The McGraw-Hill Book Co., New York, 1940.
- Deutsch, Helene, Psychology of Women, Grune and Stratton, New York, 1942.
- Grune and Stratton, Psychology of Women, Motherhood, Vol. II, New York, 1942.
- Engel, G. S., and G. W. F. Pearson, Emotional Problems of Living, W. W. Norton Co., New York, 1943.
- Poster, Robert, and Pauline Wilson, Women after College, Columbia University Press, 1942.
- Hendricks, Ives, Psycho-analysis, Alfred A. Knopf, New York, 1942.
- Hollingsworth, Leta, Gifted Children, Their Nature and Nurture, The Macmillan Co., New York, 1933.
- Kanner, Leo, Child Psychiatry, Charles C. Thomas, Baltimore, Md., 1935.
- "Early Behavior Problems as Signposts to Later Maladjustment," The American Journal of Psychiatry, Vol. 67, No. 6, 1951-1952.
- Levy, David, Maternal Overprotection, Columbia University Press, New York, 1943.
- Spilling, Mervyn, Oxford University Press.
- Lorenz, Sander, Editor, Psycho-analysis Today: Its Scope and Limitations, Coward-McCoy Publishers, New York, 1935.

Lowrey, Lawson G., Psychiatry for Social Workers, Columbia University Press, New York, 1946

Menninger, Karl A., Man against Himself, Harcourt, Brace and Company, New York, 1938

Ribble, Margaret, The Rights of Infants, Early Psychological Needs and their Satisfaction, Columbia University Press, New York, 1943

Roe, A. and D. Shakow, "Intelligence in Mental Disorder," Academy of Sciences, New York, pp. 361-490

Stoddard, George D., The Meaning of Intelligence, The Macmillan Company, New York, 1945

Strecker, Edward, Fundamentals of Psychiatry

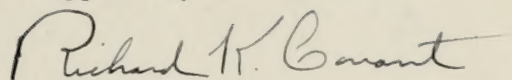
_____ and Ebaugh, Clinical Psychiatry

Thom, Douglas, Everyday Problems of the Everyday Child

Wechsler, David, Measurement of Adult Intelligence, Williams and Wilkins, Baltimore, Md., 1944

White, William A., Outline of Psychiatry

Approved,



Richard K. Conant, Dean

Lowrey, Lawson G., Psychiatry for Social Workers, Columbia University Press, New York, 1948

Menninger, Karl A., Man Against Himself, Harcourt, Brace and Company, New York, 1938

Albrie, Margaret, The Rights of Infants, Early Psychological Needs and their Satisfaction, Columbia University Press, New York, 1943

Roe, A. and D. Shew, "Intelligence in Mental Disorder", Academy of Sciences, New York, pp. 381-420

Stoddard, George D., The Meaning of Intelligence, The Macmillan Company, New York, 1945

Strecker, Edward, Foundamentals of Psychiatry

_____ and Korsch, Clinical Psychiatry

Thom, Douglas, Everyday Problems of the Everyday Child

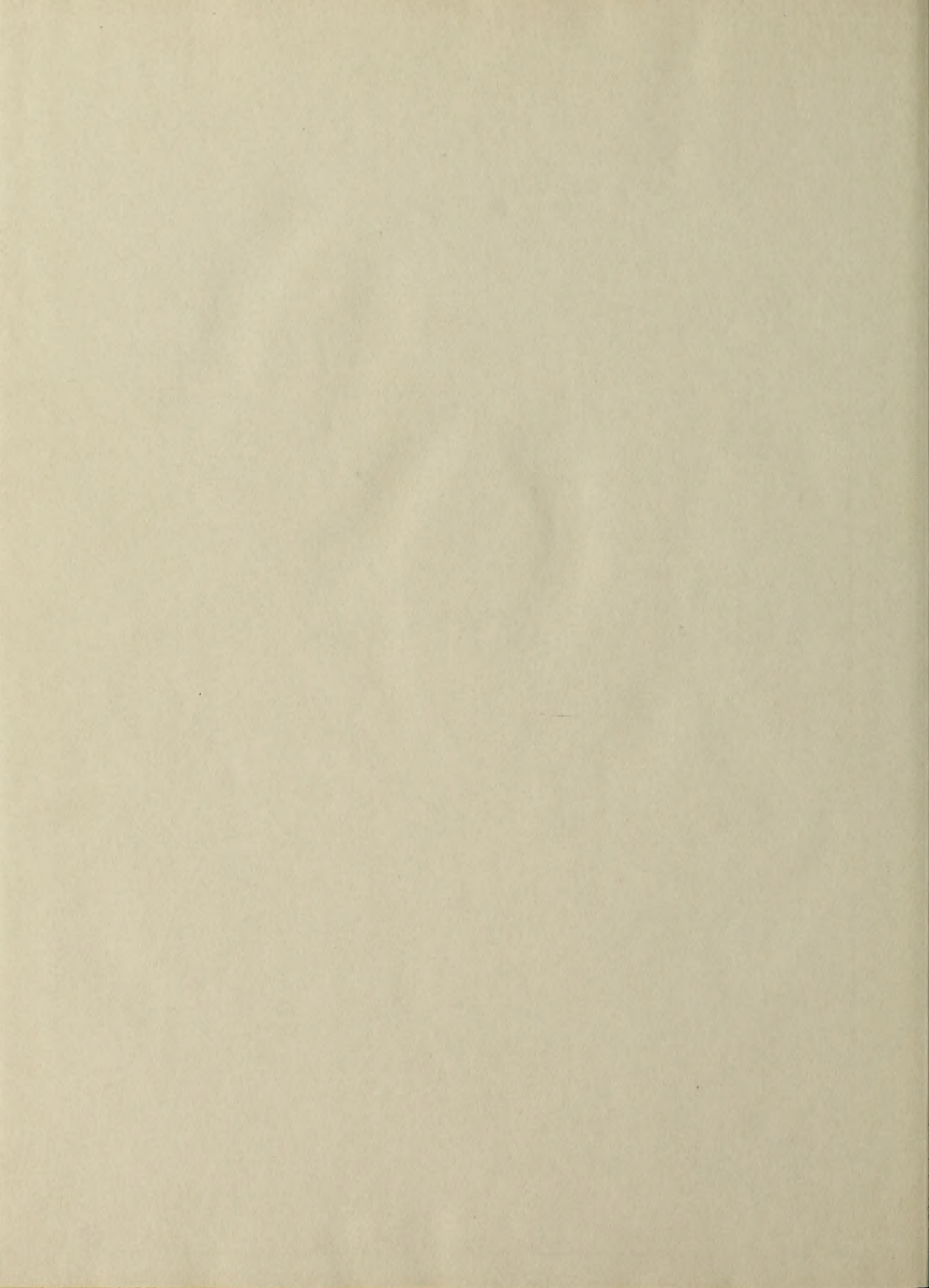
Wechsler, David, Measurement of Adult Intelligence, Williams and Wilkins, Baltimore, Md., 1944

White, William A., Outline of Psychiatry

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